

§ 417.530

(1) The Medicare enrollee is covered under the plan; and

(2) Under section 1862(b) of the Act, CMS is precluded from paying for the covered services .

(d) *Responsibilities of HMO or CMP.* An HMO or CMP must—

(1) Identify payers that are primary to Medicare under section 1862(b) of the Act;

(2) Determine the amounts payable by these payers; and

(3) Coordinate the benefits of its Medicare enrollees with these payers.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38080, July 15, 1993; 60 FR 46229, Sept. 6, 1995]

Subpart O—Medicare Payment: Cost Basis

SOURCE: 50 FR 1346, Jan. 10, 1985, unless otherwise noted.

§ 417.530 Basis and scope.

This subpart sets forth the principles that CMS follows to determine the amount it pays for services furnished by a cost HMO or CMP to its Medicare enrollees. These principles are based on sections 1861(v) and 1876 of the Act and are, for the most part, the same as those set forth—

(a) In part 412 of this chapter, for paying the costs of inpatient hospital services which, for cost HMOs and CMPs, are considered “reasonable” only if they do not exceed the amounts allowed under the prospective payment system; and

(b) In part 413 of this chapter, for the costs of all other covered services.

[60 FR 46230, Sept. 6, 1995]

§ 417.531 Hospice care services.

(a) If a Medicare enrollee of an HMO or CMP with a reasonable cost contract makes an election under § 418.24 of this chapter to receive hospice care services, payment for these services is made to the hospice that furnishes the services in accordance with part 418 of this chapter.

(b) While the enrollee’s hospice election is in effect, CMS pays the HMO or CMP on a reasonable cost basis for only the following covered Medicare

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services furnished to the Medicare enrollee:

(1) Services of the enrollee’s attending physician if the physician is an employee or contractor of the HMO or CMP and is not employed by or under contract to the enrollee’s hospice.

(2) Services not related to the treatment of the terminal condition for which hospice care was elected or a condition related to the terminal condition.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993; 60 FR 46230, Sept. 6, 1995]

§ 417.532 General considerations.

(a) *Conditions and criteria for payment.*

(1) The costs incurred by the HMO or CMP to furnish services covered by Medicare are reimbursable if they are—

(i) Proper and necessary;

(ii) Reasonable in amount; and

(iii) Except as provided in § 417.550, appropriately apportioned among the HMO’s or CMP’s Medicare enrollees, other enrollees, and nonenrolled patients.

(2) In determining fair and equitable payment for the HMOs or CMPs, CMS generally applies the cost payment principles set forth in § 413.5 of this chapter.

(3) In judging whether costs are reasonable, CMS applies the weighted average of the AAPCCs of each class of the HMO’s or CMP’s Medicare enrollees (as defined in § 417.582) for the HMO’s or CMP’s geographic area as an absolute limitation on the total amount payable.

(b) *Method and amount of payment to the HMO or CMP.* (1) CMS makes interim per capita payments each month for each Medicare enrollee, equivalent to the interim per capita cost rate determined in accordance with § 417.570.

(2) CMS adjusts the interim per capita rate as necessary during the contract period and makes final adjustments at the end of the contract period.

(3) In determining the amount due the HMO or CMP, CMS deducts from the reasonable cost actually incurred by the HMO or CMP for covered services furnished to its Medicare enrollees, an amount equal to the actuarial value of the applicable Medicare Part